

Gateway Dental Centre  
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**ADVANCE CONSENT TO TREAT MINOR CHILD**

I, \_\_\_\_\_, the parent or legal guardian of my child, \_\_\_\_\_, hereby authorize and consent to the rendition of routine and emergency dental treatment for my child when deemed necessary by licensed dentist(s) and qualified dental personnel of Gateway Dental Centre. This authorization will remain in effect until revoked in writing by me and this authorization shall remain a permanent part of my child’s Gateway Dental Centre treatment record.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Signature of parent/legal guardian

**IMPORTANT PLEASE READ**

This document will not be accepted as authorization by Gateway Dental Centre and its licensed dentist(s) and qualified dental personnel prior to the rendition of an initial comprehensive or emergency dental examination and other diagnostic tests and radiographs. The parent or legal guardian must be present at the initial comprehensive or emergency dental visit. Gateway Dental Centre reserves the right to require the presence of the parent or legal guardian at any or all future dental visits at the election of its licensed dentist(s) and qualified dental personnel.

**NOTE: PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, THIS IS A PROPRIETARY DOCUMENT THAT CONTAINS PROTECTED HEALTH INFORMATION. THIS DOCUMENT MAY NOT BE VIEWED BY PERSONS FOR WHICH THE INFORMATION APPEARING HEREIN IS NOT LEGITIMATE JOB RELATED INFORMATION ASSOCIATED WITH RENDERING HEALTH TREATMENT OR APPROPRIATE ADMINISTRATIVE SUPPORT TO THE PATIENT.**